Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-14-1725-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid a total of $9,451.98 on 10/14/13 however our facility was under paid per the APC rate."

Amount in Dispute: $7,609.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Pine Creek Medical Center has been appropriately reimbursed for services rendered to (claimant) for the 08/28/2013 date(s) of service."

Response Submitted by: Liberty Mutual Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2013	29823	$7,609.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the guidelines for coding, billing, reporting, and reimbursement of professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z652 – Recommendation of payment has been based on a procedure code which best describe services rendered.
   - X263 – The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support level of service billed with medical documentation?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, X263 – "The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure." 28 Texas Labor Code §134.202(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of the submitted documentation, "OPERATIVE REPORT" finds mention of only one area of debridement, "labrum at the biceps". Therefore, the carrier's denial is supported as only one area is supported by the medical record.
2. Level of service as described by CPT code not supported by medical record. No separate payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.